Interjurisdictional Tuberculosis Notification for Latent TB Infection (LTBI) Minnesota Department of Health

REFERRING PROVIDER INFORMATION:

Jurisdiction: (clinic, city, county, state) _____

Contact person making referral: _____

Phone: _____ ext. _____ Fax: _____

LTBI REFERRAL STATUS:

LTBI: ☐ Reactor (LTBI) ☐ Converter (LTBI)

Indication for screening:

☐ medical condition (e.g. HIV, diabetes, immunosuppressed, organ transplant, chemical abuse)

☐ foreign born ☐ recent contact of infectious TB case ☐ homeless

☐ employee screening ☐ correctional facility inmate ☐ migrant worker

☐ stable, inactive TB on CXR ☐ drug treatment facility resident ☐ nursing home resident

☐ other _____

PATIENT INFORMATION:

Patient name: (last) _____, (first) _____ (middle) _____

AKA (alias): _____

DOB: _____ / _____ / _____ Gender: ☐ Male ☐ Female

New address: (street) _____

(city) _____(state) _____ (zip) _____

New phone number: (home) _____ (cell) _____

Email: _____

Date of patient's expected arrival to new jurisdiction: _____ / _____ / _____

Patient's country of origin: ☐ United States ☐ Other _____

Patient's primary language: _____ Is interpreter needed? ☐ No ☐ Yes

Emergency contact: (name) _____ (phone) _____

(relationship to patient) _____

SCREENING RESULTS:

TB skin test date: ____ / ____ / ____ Result: _____ (mm) ☐ Test not done

IGRA date: ____ / ____ / ____ Result: ☐ Positive ☐ Negative ☐ Test not done

☐ Indeterminate ☐ Borderline (T-Spot only)

CXR or CT date: ____ / ____ / ____ Result: ☐ Normal ☐ Abnormal, not consistent with active TB

☐ Other: (attach copy of report) _____

MEDICATIONS / TREATMENT:

Tx start date: _____ / _____ / _____ ☐ Tx not started

Medication / dose: _____

Indication for Vitamin B6 (if applicable): _____

Number of bottles given: _____ or Total number of doses: _____

Date of last bottle given: _____ / _____ / _____

Tx adherence notes or additional comments: _____

_____

_____